

Photo/Video Release Form

I understand that services provided by Panhandle Health District may include medical procedures and that my health care information is protected under Idaho Code 9-340C(13). I authorize the media and/or Panhandle Health District to broadcast or publish any videotape/photographs and/or interview/testimonial taken of me during these procedures and special events, and that Panhandle Health District may use these videos/photographs and/or interview/testimonial of me on its social media sites, website, publications or newspaper articles. I understand that I will not be compensated for the use of my information, photograph/video or quote.

My initials below indicate that I authorize Panhandle Health District to use and/or disclose the following information about me:

_____ All photographs, videos, quotes/interviews of me may be used indefinitely unless I revoke this release.

_____ My name, age, city, county and state of residence.

This release form is good for one year from the date of signature.

Signature _____ Date _____
(If subject is a minor child under the age of 18, a parent or guardian must sign)

Printed Name _____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or my eligibility for services.

Finally, I understand that I may revoke this authorization at any time, provided that I do so in writing. I understand that information released between the effective date of this authorization and the date of the revocation may still be used in the public domain.

Additional Information About the Photo

1. Name of person/people in photo: _____
2. Location of photo (if not a photo of people): _____
3. Description of photo: _____
4. Name of photographer: _____
5. Other information you wish to provide: _____
